Schizophrenia & Psychosis Action Alliance

**Testimony to the Commission to Study Mental and Behavioral Health in Maryland** 9-13-22
by Evelyn Burton, Maryland Advocacy Chair, Schizophrenia & Psychosis Action Alliance.

The Schizophrenia & Psychosis Action Alliance greatly appreciates all the time and attention that the Commission and especially Lt. Governor Rutherford, have devoted to the barrier to treatment caused by Maryland's undefined danger standard for involuntary psychiatric evaluation and hospital treatment. Not only have you listened closely for 3 years to the tragedies and struggles of the many families and professionals that have testified before you, but you have also taken steps to initiate corrective actions to remove the existing barrier. For this we are extremely grateful. It renews our hope that our loved ones with serious mental illness, who are unable to recognize their need for treatment, may finally get the care and treatment they need and deserve, and recovery may at long last be possible.

Below are the comments submitted to the Maryland Register by the Schizophrenia & Psychosis Action Alliance on the proposed regulation amendments to define the danger standard. I want to discuss especially items number 3 and 4 in those comments, since they relate to issues that have not been discussed in our previous testimony to the Commission.

We had expected that proposed regulations would cover all sections of the Maryland statute that include the danger standard. However, the proposed danger stand definition is only included as part of regulations that relate to one section of the statute, namely the completion of certificates by medical professionals for involuntary hospital admission. There is no reference to the proposed danger definition in regulations for statutes relating to emergency petition criteria, the hospital admission responsibility, involuntary admission criteria used at the commitment hearing, or criteria for judicial commitment of a criminal justice inmate. This is needed to ensure that all professionals involved in those procedures will clearly understand that the new danger definition applies to them as well. We still believe that this goal could best be accomplished by including the danger standard definition in statute, to which non health professionals, such as peace officers and judges primarily look for guidance. However, if done in regulations, at least there should be regulations that address all pertinent sections of the statute.

Our other new concern is the addition of the words "shall experience an incident" in the proposed danger standard definition, which were not included in the definition presented to the Commission by the Health Department in July. "Incident" can viewed as an overt act. We are concerned that this might exclude those who have experienced gradual deterioration such that they are no longer able to adequately care for their basic survival needs. This situation may only involve "passive" behavior, such an inadequate intake of food or water. We suggest either eliminating the words "shall experience an incident" or add language clarifying that both active and passive behavior should be considered. (See suggested language at the end of this document.).

Below are the complete comments submitted to the Maryland Register on the proposed regulations to define the danger standard.

**The Schizophrenia & Psychosis Action Alliance appreciates the Department of Health's (MDH) willingness to define the danger standard for involuntary hospital admission with the proposed amendments to COMAR 10.21.01.04 and 10.21.01.08 to improve access to hospital treatment.**

The proposed regulation amendments will facilitate access to hospital treatment for some with serious mental illness (SMI), who presently are denied treatment because the currently undefined danger standard is often interpreted narrowly as meaning only suicidal or homicidal. However, the proposed amendments lack several provisions to enable access for many others with SMI who because of their illness, are unable to recognize their desperate need for treatment. Without the recommended revisions below, the proposed regulations will perpetuate the current barrier to care, for individuals experiencing the psychiatric deterioration of psychosis or mania but have not deteriorated yet to be at imminent risk of physical harm to self, as the danger standard is often currently interpreted. For many of these extremely ill individuals, this denial of timely treatment will continue to result in suicide, incarceration, homelessness, victimization, violence and death, the consequences of non-treatment of serious mental illness.

We apricate the Secretary's proposed changes. However, we respectfully recommend the 5 revisions and the language below, to better promote uniform interpretation of the danger standard across the state, and greatly improve access to timely treatment for the most vulnerable with SMI. Especially for those with psychosis, research shows that prompt treatment is critical to prevent destruction of brain matter and to promote the likelihood of a meaningful recovery.

1. **Include an explicit statement that the danger need NOT be imminent.** Nowhere in the proposed regulations is it made clear that imminent danger is not required. As many families have testified for over 20 years, the common imminent danger interpretation has created a widespread barrier to timely treatment. Extensive training on this was done in 2001-2002 after the word "imminent" was removed by the legislature from the danger standard language for emergency petition. However, training alone was inadequate to prevent many peace officers, clinicians, and judges from continuing to believe that the danger must be imminent. To change this common misconception by so many, an explicit statement is needed in the Regulations, that imminent danger is not required.

**2. Clarify that "psychiatric care" is medical care and "significant psychiatric deterioration" is a form of harm to self.** The Behavioral Health Administration's Stakeholder Report on the danger standard acknowledges the research, linking untreated psychosis to irreversible brain damage, including the destruction of brain cells. The report cites research that found "first-episode psychosis (FEP) can result in a loss of up to 1% of total brain volume and up to 3% of cortical gray matter." Psychosis has been likened to a slow moving stoke, which , like a stroke requires immediate treatment to prevent brain damage. Thus, psychosis should be considered a current and acute issue causing harm to self. It was made clear at the stakeholder meetings that the MDH use of the words "medical care" does not include psychiatric care and "illness" does not include "psychiatric illness". How do you justify denying treatment to those with psychosis, until their brain deteriorates to the point when they can no longer care for their "physical" needs, attempt suicide or become violent. It is inhumane and promotes violence, incarceration, and suicide. Half of all states have psychiatric deterioration standards as a form of harm to self and have reported no problems because of it, only benefits and more states are adding it each year, such as Louisiana, which added it this year. The Department needs to clarify that significant psychiatric deterioration is a form of harm to self , to best meet the state's policy, as stated in Health General §10–102: "to foster and preserve the mental health of its citizens; and to that end, to provide without partiality care and treatment to citizens who have mental disorders."

3. Add **language specifying that an individual's personal, medical, and psychiatric history, if available, must be considered.** Currently, police, medical professionals and judges are often under the impression that they are not permitted to consider an individual's past symptoms in evaluating their current dangerousness. MDH should not only permit but require the use of any available history to make an informed decision. History such as past serious suicide attempts when not taking prescribed

medication is of vital life and death importance in assessing current dangerousness for an individual who is currently not taking prescribed medication and experiencing psychiatric deterioration.

4. **Make the proposed changes uniform across all regulations pertaining to danger to self or others.** The proposed amendments to COMAR 10.21.01.04 apply only to the completion of certificates by medical professionals that accompany an application for involuntary hospital admission. Therefore, this offers no clarity that the proposed definition of the danger standard should apply to all sections of the statute and regulations that cite the danger standard. This includes Health General §10–617, §10–622, §10–623, §10–626, and §10–632, and their associated regulations. These cover standards for emergency petition, commitment hearing decision, hospital standards, and judicial orders for incarcerated inmates. Regulations are needed for each of these sections to specify that the proposed danger standard applies in all of these situations. This would offer appropriate uniform guidance to police, outpatient clinicians, and judges who apply the law for involuntary evaluation and treatment.

5. Make clear that the use of the words "shall experience an incident" in the proposed definition do not limit application of the danger standard to those exhibiting overt acts and exclude those who have gradually deteriorated to a dangerous state. This could be accomplished by stating: "shall experience an incident ***OR EXHIBIT ACTIVE OR PASSIVE BEHAVIOR*** ".

In conclusion we recommend the following language:

For an individual to meet the requirements as presenting a danger to the life or safety of the individual or others, ***IN CONSIDERATION OF THE INDIVIDUAL'S PERSONAL, MEDICAL AND PSYCHIATRIC HISTORY IF AVAILABLE***, the individual shall experience an incident ***OR EXHIBIT ACTIVE OR PASSIVE BEHAVIOR*** that:
(1) Is recent and relevant to the danger which the individual may currently present, *HOWEVER IMMINENT DANGER IS NOT REQUIRED;*
(2) Arises as a result of the presence of a mental disorder; and
(3) Includes, but is not limited to, one of the following scenarios:
(a) The individual has threatened or attempted suicide, or has behaved in a manner that indicates an intent to harm self, or has inflicted or attempted to inflict bodily harm on self or another;
(b) The individual, by threat or action, has placed others in reasonable fear of physical harm; or
(c) The individual has behaved in a manner that indicates they are unable, without supervision and the assistance of others, to meet their need for nourishment, medical care, ***PSYCHIATRIC CARE***, shelter or self-protection and safety such as to create a substantial risk for bodily harm, serious illness, ***SIGNIFICANT PSYCHIATRIC DETERIORATION***, or death. **PSYCHIATRIC DETERIORATION" MEANS A DECLINE IN MENTAL FUNCTIONING, WHICH DIMINISHES THE PERSON'S CAPACITY TO REASON OR EXERCISE JUDGMENT.**

Thank you for considering our comments.

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# MARYLAND PSYCHIATRIC SOCIETY



September 8, 2022

Via email to mdh.regs@maryland.gov

**Maryland Psychiatric Society comments on proposed changes to COMAR 10.21.01 Involuntary Admission (IVA) to Inpatient Mental Health Facilities**

The Maryland Psychiatric Society (MPS) appreciates the Involuntary Commitment Stakeholders' Workgroup and its August 11, 2021 report. Our member psychiatrists are integrally involved in caring for people with severe behavioral illnesses and involuntary commitment may be the best course for some of those individuals. We agree that there are times when people are at significant risk to themselves or others, yet they are not retained. This serious problem can lead to reluctance to even begin the emergency petition process or to rely on voluntary commitment (which can result in premature discharge) when there is concern that others may interpret the statute differently. In some very heart wrenching instances, the result is tragic.

The Workgroup outlined three recommendations. The MPS supports the recommendation to provide more information and training around the existing dangerousness standard, which readily accommodates a range of gray area situations involving serious risk to the individual or others. We also support the recommendation to gather more data about how the current system is working. Although it is initially appealing, we disagree with the recommendation to refine the dangerousness standard in regulations, yet to our knowledge this is the only action being taken at this time. The proposed regulation gives the appearance of addressing the conflict between civil liberty and safety but does not provide a comprehensive solution in our view.

Even though the proposed definition of "danger to the life or safety" is more detailed and prescriptive, **the changes significantly narrow the ability to use involuntary commitment**, so there will still be instances when the individual is not retained but should have been. For example,

- It requires the patient to be "unable" to care for self, but few would meet this standard because it requires complete disability.
- It does not include significant destruction of property.
- "Reasonable fear of physical harm" can still be interpreted differently.
- Although there is similar risk with the existing regulation, the definitions could be mis-used.
- It requires overt acts.

**We respectfully request that the changes to COMAR 10.21.01 be limited to updating the health care professionals who are authorized to complete a certificate.**

Involuntary admissions are needed to keep patients safe when resources in the community are not available. These regulatory changes aim to address a problem that mainly stems from inadequate resources for people suffering acute mental health crises. Maryland needs more inpatient beds at both private and state hospitals. This deficiency can lead to individuals being inappropriately released from the emergency department when there is an ambiguous situation and no bed availability. We also need more specialized, high quality, community-based alternatives to hospitalization. This is the starting point for a comprehensive solution, in addition to training and gathering data.

Thank you for the opportunity to provide input. Please email heidi@mdpsych.org with questions.

Sincerely,

Jessica V. Merkel-Keller, M.D.

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President